# *Memorandum of Understanding.*

*Investigating patient or client safety incidents (Unexpected death or serious untoward harm):*

DHSSPS
Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk


hseni
CONTROLLING RISK TOGETHER

Northern Ireland
Courts and Tribunals Service
www.courtsni.gov.uk

***Promoting liaison and effective communications***
*between the Health and Social Care, Police Service of Northern Ireland, Coroners Service for Northern Ireland, and the Health and Safety Executive for Northern Ireland.*

***March 2013***

# Contents

## FOREWORD

The Department of Health, Social Services and Public Safety is committed to putting patient and client safety at the forefront of everyday practice. Patient and client safety incidents may involve failures by systems or individuals. Openness in reporting and investigating safety incidents will ensure that lessons are learnt for the future.

Patient and client safety incidents involving unexpected death or serious untoward harm and requiring investigation by the Police Service of Northern Ireland (PSNI), Coroners Service for Northern Ireland (NI) and/or the Health and Safety Executive for Northern Ireland (HSENI) are rare. When such incidents happen they need to be handled correctly for the sake of public safety. Where the nature of an incident raises real questions about the possibility of criminal proceedings, the PSNI and/or HSENI may be involved in the investigation. The Coroners Service for NI will investigate unexpected or unnatural deaths.

The threshold for a detailed investigation by the PSNI or HSENI is usually set at a high level. This means that their investigations should take place only where there is clear evidence or reasonable suspicion of a criminal offence having been committed. In situations where the same incident is subject to investigation by a number of separate organisations, it is essential that there is clarity of roles and responsibilities, effective liaison and communication between all parties involved. This Memorandum of Understanding (the memorandum) seeks to ensure effective arrangements are in place for incidents of this nature.

The memorandum is intended to help:

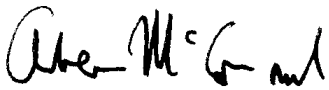
- identify which organisations should be involved and the lead investigating body;
- prompt early decisions about the actions and investigation(s) thought to be necessary by all organisations and a dialogue about the implications of these;

- provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high level decisions are taken;
- ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

The memorandum addresses issues concerning strategic liaison and all guidance in this memorandum will defer to the overarching principle of the protection and preservation of life.

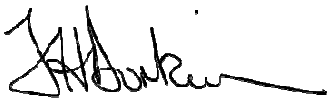
The memorandum is supported by policies, procedures and other operational guidelines produced by the respective organisations.

We commend the memorandum to you:

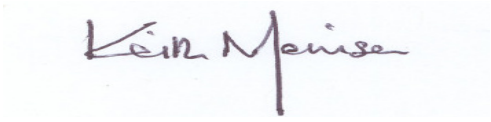


**Andrew McCormick**
Permanent Secretary
Department of Health,
Social Services & Public Safety.

**John Roberts**
D/Superintendent
Police Service of
Northern Ireland.



**Jacqui H. Durkin**
Chief Executive
Northern Ireland Courts and Tribunals Service.



**Keith Morrison**
Chief Executive
Health and Safety Executive
for Northern Ireland.

## INTRODUCTION

1. The memorandum has been agreed between the Department of Health, Social Services and Public Safety (DHSSPS), on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSCS in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS. It sets out the general principles for the HSCS, PSNI, Coroners Service for NI and HSENI to observe when liaising with one another.

2. For the purposes of the memorandum an HSC patient or client is defined as: 'A person receiving health and/or personal social services under The Health and Personal Social Service (Northern Ireland) Order 1972'.

3. The memorandum focuses on high level/strategic communication and co-ordination by DHSSPS[1], HSCS, PSNI, HSENI and Coroners Service for NI to ensure appropriate organisations to be involved in the investigation are identified and the lead investigating body determined at an early stage.

4. The purpose of the memorandum is to promote effective communication between the organisations. The memorandum will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for NI or HSENI separately or jointly. This may be the case when an incident has arisen from or involved

[1] DHSSPS Pharmacy Branch Inspection and Investigation Team have statutory responsibility under various legislative frameworks including the Medicines Act, Misuse of Drugs Act and Pharmacy Order.

criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.

5. Other causes of patient or client death (such as industrial diseases) should be referred to the coroner (see Appendix 1). These would not require investigation of the HSC organisation or its employees under this memorandum.

6. Similarly, some accidents to patients or clients are required to be reported to HSENI by HSC organisations under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 (RIDDOR). HSENI will normally investigate all reportable fatal accidents under RIDDOR that '*arise out of or in connection with work',* but not accidents to patients that arise from medical treatment or diagnosis. (see Appendix 2)

**Roles and responsibilities of the Organisations and Other Relevant Bodies**

7. HSC organisations, DHSSPS, PSNI, Coroners Service for NI and the HSENI have various roles and responsibilities in relation to investigating patient or client safety incidents in the HSCS.

8. The HSC organisations have a responsibility, among other things, to ensure the safety and well being of patients or clients and staff and to investigate when things go wrong. This responsibility is placed upon every HSC Chief Executive, as well as upon the Board of their organisation and is a critical component of corporate and clinical and social care governance. In discharging this responsibility, the HSC organisations must have policies and procedures that conform to national and local standards. They should also ensure that the requirements of the memorandum operate effectively alongside procedures and protocols established in the areas of child protection and the protection of vulnerable adults.

9. The PSNI also has a duty to uphold public safety, investigate all criminal offences and, in doing so, will seek to balance matters of public safety against the need to prosecute. The types of patient or client safety incident that should prompt a HSC organisation at some stage to seek the involvement of the PSNI are those that display one or more of the following characteristics:

- evidence or suspicion that the actions leading to harm were intended;
- evidence or suspicion that adverse consequences were intended;
- evidence or suspicion of gross negligence and/or recklessness, in a serious safety incident, including as a result of failure to follow safe practice or procedure or protocols.

10. HSENI is responsible for the enforcement of the Health and Safety at Work (Northern Ireland) Order 1978 (HSWO). It seeks to ensure that risks to people's health and safety from work activities are effectively controlled. Generally speaking, HSENI does not seek to apply the HSWO to matters of clinical judgement or to the level of provision of care. Although HSENI is responsible for enforcing work-related health and safety legislation in a large variety of settings including hospitals and nursing homes, District Councils have this responsibility where the main activity is the provision of permanent or temporary residential accommodation e.g. statutory residential homes and other residential homes. If the HSC organisation is unsure, who to report work-related health and safety issues to, they should contact HSENI for advice.

11. Coroners have a responsibility under the Coroners Act (Northern Ireland) 1959 to investigate the cause and circumstances of deaths in cases reported to them that appear to be unexpected or unexplained, a result of violence, the result of an accident, a result of negligence, or a result of any cause other than natural illness or disease. Appendix 1 sets out guidelines on reporting deaths to the coroner.

12. Other organisations may also have a role in investigating patient or client safety incidents at local or national level. These include the HSC Board/Public Health Agency[2], Regulation and Quality Improvement Authority (RQIA), the Northern Ireland Adverse Incident Centre (NIAIC), and professional regulatory bodies (see Appendix 3 for details).

**Strategic Communication and Decision Making**

13. In cases where more than one organisation may/should have an involvement in investigating any particular incident, it is the responsibility of the HSC organisation to report to each of these organisations as appropriate. The criteria for reporting to each of these organisations under the memorandum are contained in Appendix 3.

14. When organisations are notified of an incident, it is their responsibility to consider if the incident should be investigated by their organisation, or reported to any of the organisations who are signatories to the memorandum. If several organisations are involved they should consider if a Strategic Communication and Decision Making Group (the Group), meeting is required.

15. The purpose of the Group is to provide strategic oversight of a patient safety incident investigation involving the PSNI, Coroners Service for NI and/or HSENI. The meeting will allow:

- Organisations to set out their needs so that actions can be agreed that do not prejudice the work of each organisation;
- Clarification of the role of individual organisations involved;
- Determination of the appropriate body with primacy responsibility to investigate and take the lead in co-ordinating with others;
- Co-ordination of multiple investigations;
- Meetings of the Group may be virtual as well as face to face.

[2] From May 2010 Serious Adverse Incidents are Reported to the Health and Social Care Board. http://www.dhsspsni.gov.uk/hsc__sqsd__08-10__2_.pdf

16. The HSC organisation should continue to ensure patient or client safety, but not undertake any activity that might compromise any subsequent statutory investigations. If in doubt, the HSC organisation should at the same time contact other parties likely to be involved in the investigation.

17. HSC organisations should have robust procedures in place to ensure the preservation and security of physical, scientific and documentary evidence. In the first instance it is the responsibility of the HSC Trust until such times as an investigating body arrives and takes control of it.

18. Any organisation that is a party to the memorandum may request a meeting of the Group by contacting Safety Quality and Standards Directorate at DHSSPS.
Tel: 028 90 528561
Email qualityandsafety@dhsspsni.gov.uk

19. Where more than one organisation is involved in investigating an incident primacy of investigation must be considered by the Group.

20. Those who attend the meeting on behalf of the HSC Board/PHA should be sufficiently independent of the HSC Trust and not have any direct involvement in the incident.

21. Where possible, the statutory investigating bodies will come to an early view about the nature of the incident and where responsibility for any future investigation lies. For instance, the PSNI and HSENI may conclude that they have no further role in the matter. On some occasions it may be decided that the HSC organisation should investigate further and if more information or evidence comes to light convene another meeting of the Group to discuss its findings. This will provide an opportunity for the PSNI, or HSENI to decide if they need to conduct their own investigation or if some other course is appropriate.

22. The precise nature of what is discussed at the meeting will be determined by local circumstances including the nature of the incident.

23. There will be occasions when the incident may raise important concerns about wider patient or client safety. In such circumstances, the conduct of any further HSC investigations will need to be considered by the Group so that the necessary further investigation by the HSC can be conducted in such a way as to avoid the danger of prejudicing the PSNI, Coroners Service for NI and/or HSENI investigation e.g. by interviewing members of staff who may subsequently give evidence at court.

**Securing and Preserving Evidence**

24. It is easy in the immediate aftermath of a patient or client safety incident to overlook the need to secure and preserve evidence including records. This may be particularly true of busy clinical areas that are in constant use by patients, clients and staff and when people are following routine operational practice within their organisation e.g. sterilising a piece of equipment after a procedure or operation.

25. However, the safeguarding of physical, scientific and documentary evidence may be critical to understanding what has happened and thereby protecting public safety and the conduct of a satisfactory investigation by any agency. Destruction of evidence may also delay putting safety measures in place. It may also lead to a more protracted and complex investigation than would otherwise have been necessary. For example, the absence of the product, instructions for use, packaging and batch number or other means of identification of a piece of equipment may lead to a delay in effectively investigating an adverse incident, or issuing an alert to the HSCS.

26. Where a criminal offence is suspected then it is especially important that evidence is retained, since failure to do so may mean that legal proceedings are undermined.

27. Even in those incidents where concerns arise long after the event, it is important to make every effort to secure and preserve all available evidence.

28. A record must also be kept and receipts obtained wherever possible of any HSC documents, records, or any other items passed to other agencies.

29. HSC organisations should raise awareness of this issue amongst staff and have robust policies and procedures to deal with the preservation of evidence.

**Supporting Patients, Clients, Relatives, HSC Trust Staff or those Injured**

30. In the event of a patient or client safety incident it is important that the HSCS, PSNI, Coroners Service for Northern Ireland and/or HSENI work together to keep patients, clients, relatives, HSC staff and injured parties informed. The organisations should therefore, as far as possible, agree and follow a liaison strategy for each incident. Such a strategy should be agreed at the first meeting of the Group and reviewed as necessary at subsequent meetings.

**Handling Communications**

31. A communications strategy needs to be agreed for dealing with patients, clients, relatives, other organisations and the media. Where possible, the organisations need to take a common approach to communications although in the event of legal proceedings this may not be practicable. Specialist help and advice should be sought as necessary.

**Review**

32. The memorandum will be reviewed at the bi-annual meetings of the Working Group convened by the DHSSPS or at the request of an organisation that is a signatory to the MoU to consider:

- Working of the memorandum ;and

- Update of information in the memorandum

33. The Working Group may be contacted at:

Tel: 028 9052 8561

E-Mail: qualityandsafety@dhsspsni.gov.uk

**APPENDIX 1**

## REPORTING DEATHS TO THE CORONER

There is a general requirement under section 7 of the Coroners Act (Northern Ireland) 1959 that any death ***must*** be reported to the coroner if it resulted, *directly or indirectly,* from *any* cause other than natural illness or disease for which the deceased had been *seen* and *treated* within 28 days of death.

The duty to report arises if the medical practitioner has *reason to believe* that the deceased died *directly or indirectly:*

- as a result of violence, misadventure or by unfair means;
- as a result of negligence, misconduct or malpractice or where a medical mishap is alleged;
- from any cause other than natural illness or disease;
- from natural illness or disease for which the deceased had not been seen and treated by a registered medical practitioner within 28 days of death;
- death as the result of the administration of an anaesthetic; and
- in any circumstances that require investigation.

***All medical practitioners are under a statutory duty to report such deaths.***

In essence this means a requirement to report:

- all deaths from unnatural causes. ***It is the underlying cause that determines the need to report rather than the terminal event e.g. bronchopneumonia due to immobilisation due to a fractured neck of femur.*** For example, homicidal deaths; deaths following assault; road traffic accidents or accidents at work; deaths associated with the misuse of drugs (whether accidental or deliberate); any apparently suicidal death; deaths from the effects of hypothermia or where a medical mishap is alleged ***should always be reported;***

- any death from natural illness or disease if the deceased has not been seen and treated by a medical practitioner within 28 days of death;
- all deaths from industrial diseases e.g. asbestosis. (It is advisable to ascertain the deceased's employment history before writing a death certificate as a means of ruling out any possible industrial link – a medical history of chest disease or mesothelioma in someone who had been employed *at any time* as a shipyard worker would raise the possibility of asbestos exposure);
- all deaths on the operating table or under an anaesthetic. *NB There is no statutory requirement to report a death occurring within 24 hours of admission to hospital or of an operation – though it may be prudent to do so.* (Deaths which follow an operation necessitated by trauma should be reported to the coroner, but deaths which follow an operation necessitated by a natural illness need not be reported unless death took place before recovery from the anaesthetic);
- the death of a patient or client who had an accident in the health or social care environment (e.g. a fall in the ward);
- the death of a patient or client where there is an allegation of negligence or of a medical or nursing mishap;
- the death of a patient in the course of, or following, any clinical procedure even where the possibility of death occurring was a recognised risk of the procedure.

**APPENDIX 2**

## RIDDOR

## Reporting of Injuries, Diseases and Dangerous Occurrences (Northern Ireland) Regulations 1997

In determining if a patient or client safety incident requires to be reported under RIDDOR the following should be considered:

- The phrase 'arising out of or in connection with work' is a key component in defining, where the requirement to report a patient, or client death, or injury under Regulation 3 (1) of RIDDOR applies.
- Regulation 2(2) of RIDDOR directs that an accident due to any of the following must be regarded as 'arising out of or in connection with work'.
- 'The manner of conducting an undertaking'. This refers to the way in which any work activity is being carried out for the purposes of an undertaking, including how it is organised, supervised or performed by an employer or any of their employees, or by a self employed person.
- 'The plant or substances used for the purposes of the undertaking'. This includes, for example: lifts; air conditioning plant; any machinery; equipment, or appliance; gas installations; and substances used in connection with the premises or with processes carried on there.
- 'The condition of the premises used by the undertaking or of any part of them'. This includes the state of the structure or fabric of a building or outside area forming part of the premises and the state and design of floors, paving, stairs, lighting etc.

### Self-harm

Acts of deliberate self-harm are not considered 'accidents' and are not RIDDOR reportable. However, this does not mean that the general provisions of HSW (NI) Order 1978 do not apply. The enforcing authority may, depending on the circumstances, decide that it is appropriate to investigate such incidents. This is more likely to arise where serious management failures were a contributory factor.

**Cases where the death or injury of the patient has arisen from medical treatment or diagnosis**

If a person dies or is injured as a result of an accident arising directly from the conduct of any operation, any examination or other medical treatment being carried out by or under the supervision of a registered medical practitioner (RMP) or dentist, the death or injury is not reportable (RIDDOR regulation 10 (1)). The supervision does not need to be direct supervision for the exemption to apply – it is sufficient that the procedure being carried out was laid down by an RMP.

**Examples which are Not reportable to HSENI**

- During a surgical operation, a surgeon removes the wrong organ. The patient subsequently dies.
- A patient suffers a seizure following a medical procedure. The nursing assistant was following a procedure laid down by a registered medical practitioner.
- A paramedic administers a drug to a patient who subsequently dies as a result of an allergic reaction. This would not be reportable, whether or not the correct procedure was being followed.
- A patient known to be allergic to penicillin is nevertheless given a penicillin-based drug under the supervision of an RMP and subsequently dies.

Although HSENI may not be involved in incidents of this nature, other Bodies may have an involvement, and if there is a concern regarding the professional misconduct of an individual, you should ensure that the appropriate professional body is notified.

Further guidance is contained in "A Guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997" and "Reporting injuries, diseases and dangerous occurrences in health and social care: Guidance for employers" Health Services Information Sheet No 1 (revised) HSIS1 (Rev1).

http://www.hseni.gov.uk/riddor_guidance_on_regulations_hsa_31.pdf

**APPENDIX 3**

## REPORTING REQUIREMENTS ON HSC ORGANISATIONS UNDER THE MEMORANDUM

*Note: the following arrangements are in addition to the normal statutory reporting to HSENI.*

Consider if the incident requires involvement of each of the following organisations:

### CORONERS SERVICE for NORTHERN IRELAND

Any death **must** be reported to the coroner if it resulted, *directly or indirectly*, from *any* cause other than natural illness or disease for which the deceased had been *seen* and *treated* within 28 days of death. Appendix 1 provides fuller details.

### DEPARTMENT of HEALTH, SOCIAL SERVICES and PUBLIC SAFETY (DHSSPS)

#### Northern Ireland Adverse Incident Centre (NIAIC)

Any incidents relating to medical devices, non-medical equipment, plant and building items must be reported to the NIAIC. Guidance for reporting adverse incidents is contained in the NIAIC Device Bulletin DB2010(NI)-01

#### Pharmacy and Prescribing Branch

Pharmacy and Prescribing Branch Inspection and Investigation Team have statutory responsibility under various legislative frameworks including the Medicines Act, Misuse of Drugs Act and Pharmacy Order. These are centred particularly on the areas of misuse, diversion, illegal production and supply and inappropriate storage and record keeping as pertains to medicinal products including controlled drugs.

**Office of Social Services (Child Care Policy Directorate)**

Child deaths, including suicides, where abuse or neglect is a known or suspected factor, must be reported as set out in *Co-operating to Safeguard Children*. Also, significant incidents, including death or serious adverse events, in relation to children, who are being looked after by a Trust or Authority.

**Safety, Quality and Standards Directorate**

The Safety, Quality and Standards Directorate takes forward the Department's programme for improving the safety and quality of health and social care services delivered to people in Northern Ireland.

Until 1st May 2010 HSC organisations were required to routinely report Serious Adverse Incidents to the Department of Health, Social Services and Public Safety (DHSSPS). From this date, revised arrangements for the reporting and follow up of Serious Adverse Incidents (SAIs), pending the full implementation of the Regional Adverse Incident Learning (RAIL) system, transferred to the Health and Social Care Board (HSCB) working in close partnership with the Public Health Agency (PHA) and the Regulation Quality Improvement Authority (RQIA).

**DISTRICT COUNCILS**

Work related death of a resident or client where the main activity at the premises is the provision of permanent or temporary residential accommodation, for example a statutory residential home.

**HEALTH and SOCIAL CARE BOARD (HSCB) and PUBLIC HEALTH AGENCY (PHA)**

In line with Circular HSC (SQSD) 08/2010, responsibility for management of Serious Adverse Incident (SAI) reporting transferred from the DHSSPS (Department) to the Health and Social Care Board (HSCB) working in partnership with the Public Health Agency (PHA), with effect from 1st May 2010.

In April 2010, following consultation with key stakeholders, the HSCB issued the procedure for the 'Reporting and Follow up of Serious Adverse Incidents' for full implementation on 1 May 2010. The procedure sets out the arrangements for reporting, managing, investigating and reviewing of all SAIs occurring during the course of business of an HSC organisation, special agency or commissioned service. It also sets out the arrangements of how SAIs are managed within Primary Care Services, in conjunction with the adverse incident system in place within the Integrated Care Directorate in the HSCB.

The following criteria determine what constitutes a SAI

**SAI criteria:**

- serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self harm*) of;
  - a service user;
  - a service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two [3] years);
  - a staff member in the course of their work;
  - a member of the public whilst visiting an HSC facility;
- unexpected serious risk to a service user and/or staff member and/or member of the public;
- unexpected or significant threat to provide service and/or maintain business continuity;
- serious assault (*including homicide and sexual assaults*) by a service user:
  - on other service users
  - on staff or
  - on members of the public occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years);

[3] Mental Health Commission 2007 UTEC Committee Guidance

- serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

**HEALTH and SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)**

Any work related death of a patient or client.
The death of a patient or client which has resulted from an accident arising out of or in connection with work that is reportable under RIDDOR. This does not include *accidents to patients that arise directly from medical treatment, or diagnosis.* Appendix 2 provides further detail.

**NORTHERN IRELAND PRISON SERVICE (NIPS)**

- Any adverse incident occurring within a prison hospital which meets the criteria of an SAI would be reported in line with SAI procedure by the South Eastern Trust to the Health and Social Care Board;
- As well as the above any suspected suicide in a prison setting for someone known to mental health services, within the last two years would also be reported in line with the Regional SAI Procedure (i.e. someone known to the mental health services suspected of suicide in prison is treated no differently to any other prisoner).

**POLICE SERVICE of NORTHERN IRELAND (PSNI)**

Any incident which displays one or more of the following characteristics:

- evidence or suspicion that the actions leading to harm were intended;
- evidence or suspicion that the adverse consequences were intended;
- evidence or suspicion of gross negligence and/or recklessness, in a serious safety incident, usually as a result of failure to follow safe practice or agreed protocols.

## REGULATION and QUALITY IMPROVEMENT AUTHORITY (RQIA)

RQIA can receive reports of deaths or serious incidents involving patients and clients in relation to three specific statutory functions.

### 1. Regulated Sector Services

Deaths and serious incidents occurring in regulated services must be notified to RQIA in accordance with: -

Regulation 30 of the Nursing Homes Regulations (NI) 2005
Regulation 30 of the Residential Care Homes Regulations (NI) 2005
Regulation 28 of the Independent Healthcare Regulations (NI) 2005
Regulation 29 of the Children's Homes Regulations (NI) 2005
Regulation 29 of the Day Care Settings Regulations (NI) 2005
Regulation 33 of the Adult Placement Agencies Regulations (NI) 2007
Regulation 20 of the Voluntary Adoption Agencies Regulations (NI) 2010
Regulation 30 of the Residential Family Centre Regulations (NI) 2007

Any incident which has been reported to the police must be notified to the RQIA within 24 hours in accordance with: -

Regulation 15 of the Domiciliary Care Agencies Regulations (NI) 2007
Regulation 13 of the Nursing Agencies Regulations (NI) 2005

### 2. Mental Health Services

All untoward events relating to people suffering from a mental disorder, including death, attempted suicide, alleged assault or sexual assault must be reported by HSC providers to RQIA as set out in letter S56/2004 issued by the Mental Health Commission to Boards and Trusts in August 2005. RQIA took over the functions of the Mental Health Commission on 1 April 2009. RQIA and HSCB have agreed arrangements in place to facilitate their responsibilities in relation to such incidents.

## 3. Ionising Radiation (Medical Exposure) Regulations (IR(ME) R)

Incidents must be reported to RQIA where a patient has, or may have been, exposed to a much greater dose of ionising radiation than intended, when undergoing a medical exposure.

**APPENDIX 4**

## OTHER USEFUL CONTACTS

### General Chiropractic Council

The General Chiropractic Council was established by parliament to regulate and develop the chiropractic profession.

### General Dental Council

The General Dental Council regulates dental professionals in the United Kingdom. All dentists, dental nurses, dental technicians, clinical dental technicians, dental hygienists, dental therapists and orthodontic therapists must be registered to work in the UK.

### General Medical Council

The purpose of the General Medical Council (GMC) is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine**.**

### General Optical Council

The purpose of the General Optical Council is to protect the public by promoting high standards of education, conduct and performance amongst opticians.

### General Osteopathic Council

The General Osteopathic Council (GOsC) regulates the practice of osteopathy in the United Kingdom. By law osteopaths must be registered with the GOsC in order to practise in the UK.

**Health Professions Council**

The Health Professions Council regulate 15 health professions; arts therapists, biomedical scientists, chiropodists / podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists / orthotists, radiographers, and speech and language therapists.

**National Patients Safety Agency**

Contribute to improved, safe patient care by **informing**, **supporting** and **influencing** organisations and people working in the health sector. They are an arm's length body of the Department of Health and through three divisions cover the UK health service.

- **National Reporting and Learning Service (NRLS)**
  Aims to reduce risks to patients receiving NHS care and improve safety.

- **National Clinical Assessment Service (NCAS)**
  Supports the resolution of concerns about the performance of individual clinical practitioners to help ensure their practice is safe and valued.

- **National Research Ethics Service (NRES)**

  Protects the rights, safety, dignity and well-being of research participants that are part of clinical trials and other research within the NHS.

The Clinical Outcome Review Programme recently moved to the Health Quality Improvement Partnership (HQIP) and NCAS moved to the National Institute for Health and Clinical Excellence (NICE) on 1 April 2012. The future of the NRLS has still not been decided and NRES is currently under consideration.

**Northern Ireland Social Care Council**

The Northern Ireland Social Care Council help increase public protection by improving and regulating standards of social care workers' conduct, training and practice

**Nursing and Midwifery Council**

The Nursing and Midwifery Council regulate for England, Wales, Scotland, Northern Ireland and the Islands. It sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare consistently throughout their careers.

**Pharmaceutical Society of Northern Ireland**

The Pharmaceutical Society of Northern Ireland is the regulatory and professional body for pharmacists in Northern Ireland.

**APPENDIX 5**

## CONTACTING RELEVANT ORGANISATIONS

### CORONERS SERVICE for NORTHERN IRELAND

Mays Chambers
73 May Street
Belfast
BT1 3JL.
Tel: 028 9044 6800
Fax: 028 9044 6801
coronersoffice@courtsni.gov.uk

### DEPARTMENT of HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY (DHSSPS)

www.dhsspsni.gov.uk

### Northern Ireland Adverse Incident Centre (NIAC)

Health Estates Investment Group
Annexes 6 & 7
Castle Buildings,
Belfast
BT4 3SQ
Tel: 028 9052 3868 or 028 9052 3744
Fax: 028 9052 3900
E-Mail: niaic@dhsspsni.gov.uk

### Office of Social Services (Child Care Policy Directorate)

Castle Buildings, Stormont
Belfast BT4 3SQ.
Tel: 028 9052 0416
Fax: 028 9052 2500
E-Mail: sean.holland@dhsspsni.gov.uk

**Pharmacy and Prescribing Branch**

Inspection and Investigation Team

Castle Buildings,

Stormont

Belfast

BT4 3SQ.

Tel: 028 9052 2094

E-Mail: pharmacyadvice@dhsspsni.gov.uk.

**Safety, Quality and Standards Directorate (SQSD)**

Room D1,

Castle Buildings,

Stormont

Belfast

BT4 3SQ.

Tel: 028 9052 8561

E-Mail: qualityandsafety@dhsspsni.gov.uk

**HEALTH and SAFETY EXECUTIVE for NORTHERN IRELAND (HSENI)**

83 Ladas Drive
Belfast

BT6 9FR

Tel: 028 9024 3249

Fax: 028 9023 5383

Freephone Number:0800 0320 121

**POLICE SERVICE of NORTHERN IRELAND (PSNI)**

Crime Operations

Headquarters, Brooklyn

65 Knock Road

Belfast

BT5 6LE

Tel: 028 9070 0347

Out of Hours Tel: 028 9090 1080, ask for Call Out Senior Investigating Officer

E-mail: Jonathan.roberts@psni.pnn.police.uk

**REGULATION and QUALITY IMPROVEMENT AUTHORITY (RQIA)**

Riverside Tower

5 Lanyon Place

Belfast

BT1 3BT.

Tel: 028 9051 7500

Fax: 028 9051 7501

E-mail: info@rqia.org.uk

**HEALTH and SOCIAL CARE ORGANISATIONS**

**Health and Social Care Board (HSCB)**

**Headquarters**

12-22 Linenhall Street

Belfast

BT2 8BS

Tel: 028 9032 1313

Email: Enquiry.hscb@hscni.net

**Public Health Agency (PHA)**

Ormeau Avenue Unit

18 Ormeau Avenue

Belfast

BT2 8HS

Tel: 028 9031 1611

Fax: 028 9031 1711

Email www.publichealth.hscni.net

**Belfast Health and Social Care Trust (BHSCT)**

Trust Headquarters

A Floor

Belfast City Hospital

Lisburn Road

Belfast

BT9 7AB

Tel: 028 9032 9241

Email: info@belfasttrust.hscni.net

**Northern Ireland Ambulance Service HSC Trust (NIAS)**

Site 30

Knockbracken Healthcare Park

Saintfield Road

Belfast

BT8 8SG

Tel: 028 9040 0999

Fax: 028 9040 0900

Minicom: 028 9040 0871

Email: complaints@nias.hscni.net

**Northern Health and Social Care Trust (NHSCT)**

Headquarters
The Cottage
5 Greenmount Avenue
Ballymena
County Antrim
BT43 6DA
Tel: 084 5601 2333
Fax: 028 2563 3733
Email: chief.executive@northerntrust.hscni.net

**South Eastern Health and Social Care Trust (SEHSCT)**

Headquarters
Ulster Hospital
Upper Newtownards Road
Dundonald
Belfast
BT16 1RH
Tel: 028 9055 3100
Email: www.setrust.hscni.net

**Southern Health and Social Care Trust (SHSCT)**

Headquarters
Southern Area College of Nursing, Craigavon Area Hospital,
68 Lurgan Road,
Portadown
BT63 5QQ.
Tel: 028 3833 4444
Fax: 028 3833 5496
Email: corporate.hq@southerntrust.hscni.net

**Western Health and Social Care Trust (WHSCT)**

Headquarters

MDEC Building

Altnagelvin Area Hospital

Glenshane Road

Londonderry

BT 47 6SB

Tel: 028 7134 5171

Email www.westerntrust.hscni.net

**APPENDIX 6**

## CONTACTING PROFESSIONAL and REGULATORY BODIES

**General Chiropractic Council**

44 Wicklow Street

London

WC1X 9HL

Tel: 020 7713 5155

Fax: 020 7713 5844

E-mail: regulation@gcc-uk.org

**General Dental Council**

37 Wimpole Street

London

W1G 8DQ

Tel: 020 7887 3800

Fax: 020 7224 3294

E-mail: complaints@gdc-uk.org

**General Medical Council**

Regent's Place

350 Euston Road

London

NW1 3JN

Tel: 0845 357 0022

E-mail: practise@gmc-uk.org

**General Medical Council Belfast Office**

9th Floor Bedford House

16-22 Bedford Street

Belfast

BT2 7FD.

Tel: 028 9031 9945

E-mail: gmcnorthernireland@gmc-uk.org

**General Optical Council**

41 Harley Street

London

W1G 8DJ

Tel: 020 7580 3898

Fax: 020 7307 3939

E-mail: goc@optical.org

**General Osteopathic Council**

176 Tower Bridge Road

London

SE1 3LU

Tel: 0207 357 6655

Fax: 0207 357 0011

E-mail: info@osteopathy.org.uk

**Health Professions Council**

Park House

184 Kennington Park Road

London

SE11 4BU

Tel: 020 7840 9814

Fax: 020 7582 4874

E-mail: registration@hpc-uk.org

**National Patient Safety Agency (Corporate Office)**

4-8 Maple Street, London W1T 5HD

Tel: 020 7927 9500

Fax: 020 7927 9501

Website www.npsa.nhs.uk

**Northern Ireland Social Care Council**

7th Floor, Millennium House

19-25 Great Victoria Street

Belfast

BT2 7AQ

Tel: 028 9041 7600

Fax: 028 9041 7601

Textphone: 028 9023 9340

E-mail: info@niscc.n-i.nhs.uk

**Nursing and Midwifery Council**

23 Portland Place

London

W1B 1PZ

Tel: 020 7333 6564

E-mail: fitness.to.practise@nmc-uk.org

**Pharmaceutical Society of Northern Ireland**

73 University Street

Belfast

BT7 1HL

Tel: 028 9032 6927

Fax: 028 9043 9919

E-mail: chief.executive@psni.org.uk

**APPENDIX 7**

## OTHER RELATED DOCUMENTS

More information can be found in the following publications or via the following web sites:

Procedure for the Reporting and Follow Up of Serious Adverse Incidents.
The Health and Social Care Board, April 2010.
http://www.hscboard.hscni.net/publications/Policies/101%20Serious%20Adverse%20Incident%20-%20Procedure%20for%20the%20reporting%20and%20followup%20of%20SAI%20-%20April%202010%20-%20PDF%20268KB%20.pdf

Seven Steps to Patient Safety –the full reference Guide. The National Patient Safety Agency.
http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787

Decision Making Tool to Reduce Unnecessary Suspensions and Support a Safety Culture – The National Patient Safety Agency**.**
www.npsa.NHS.uk/idt

Maintaining High Professional Standards in the Modern NHS
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4103344.pdf

The Protection and Use of Patient and Client Information for the HPSS
http://www.dhsspsni.gov.uk/the_protection_and_use_of_patient_and_client_information_.pdf

Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance (September 2006)
http://www.hscboard.hscni.net/publications/LegacyBoards/001%20Regional%20Adult%20Protection%20Policy%20and%20Procedural%20Guidance%202006%20-%20PDF%20249KB.pdf

Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults HSC, PSNI & RQIA (July 2009)
http://www.hscboard.hscni.net/publications/16%20July%202009%20-%20Protocol%20for%20Joint%20Investigation%20of%20Alleged%20and%20Suspected%20Cases%20of%20Abuse%20of%20Vulnerable%20Adults.pdf

Information on Disclosure & Barring arrangements in Northern Ireland can be accessed at:
http://www.dhsspsni.gov.uk/svg

Co-operating to Safeguard Children, DHSSPS May 2003
http://www.dhsspsni.gov.uk/co-operating_to_safeguard_children_may_2003.pdf

Regional Child Protection Policy and Procedures
http://www.dhsspsni.gov.uk/acpcregionalstrategy.pdf

A Guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 ISBN 0 337 11259 2
http://www.hseni.gov.uk/riddor_guidance_on_regulations_hsa_31.pdf

Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse, in Northern Ireland. (September 2004)
http://www.rcpc.hscni.net/Publications/ProtocolVideoEvidence.pdf

**APPENDIX 8**

## MEMBERS OF THE REVIEW WORKING GROUP

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Armagh
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**NORTHERN IRELAND COURTS and TRIBUNALS SERVICE**

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Coroners Service for Northern Ireland

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